01. Financial Obligations of Recipients. Recipients who obtain a quantity of medication exceeding that allowed in Subsection 126.04. are responsible for payment to the pharmacy of all charges applicable to the additional quantities. This recipient responsibility applies whether or not the charges are produced by one (1) or multiple dispensing incidents. (12-31-91)

02. Excluded Drug Products. The following categories and specific products are excluded: (2-4-91)

a. Non-legend medications unless included in Subsection 126.03.b. This includes legend medications that change to non-legend status as well as their therapeutic equivalents regardless of prescription status; and (12-31-91)

b. Any legend drugs for which federal financial participation is not available; and (9-15-83)

c. Diet supplements; and (11-10-81)

d. Amphetamines, anorexiants, and related products, including, but not limited to: (11-10-81)

i. Amphetamine; and (1-16-80)

ii. Benzphetamine; and (1-16-80)

iii. Chlorphentermine; and (1-16-80)

iv. Chlortermine; and (1-16-80)

v. Dextroaphetamine; and (1-16-80)

vi. Diethylpropion; and (1-16-80)

vii. Fenfluramine; and (1-16-80)

viii. Mazindol; and (1-16-80)

ix. Methamphetamine; and (1-16-80)

x. Phendimetrazine Tartrate; and (1-16-80)

xi. Phenmetrazine; and (1-16-80)

xii. Phentermine; and (1-16-80)

xiii. Salts and optical isomers of the above listed drugs; and (1-16-80)

xiv. Combination products containing any of the above drugs. (1-16-80)

e. Ovulation stimulants including Clomiphene Citrate, Menotropins, and Urofollitropin; and (2-4-91)

f. Topical Minoxidil; and (11-10-87)

g. Nicotine chewing gum and transdermal patches; and (2-4-91)

h. Isotretinoin; and (11-10-87)

i. Topical medications whose active ingredients include either: (11-10-87)

i. Benzoyl peroxide combinations; (11-10-87)

ii. Clindamycin; (11-10-87)

iii. Erythromycin; (11-10-87)

iv. Meclomycin; (11-10-87)

v. Tetracycline; (11-10-87)

vi. Tretinoin except when prior authorized for squamous metaplasia of ocular surface epithelia. (11-10-87)

j. Vitamins unless included in Subsection 126.03.a. (12-31-91)

03. Additional Covered Drug Products. Additional drug products will be allowed as follows: (2-4-91)

a. Therapeutic Vitamins

i. Injectable vitamin B12 (cyanocobalamin and analogues); and (2-4-91)

ii. Vitamin K and analogues; and (1-16-80)

iii. Pediatric vitamin-flouride preparations; and (1-16-80)

iv. Legend prenatal vitamins for women of child bearing age; and (1-16-80)

v. Legend Folic acid; and (2-4-91)

vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (2-4-91)

vii. Legend vitamin D and analogues. (2-4-91)

b. Prescriptions for nonlegend products. (2-4-91)

i. Insulin; and (2-4-91)

ii. Disposable insulin syringes and needles; and (2-4-91)

iii. Oral iron salts. (2-4-91)

04. Limitation of Quantities. No more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (11-10-81)

a. Up to one hundred (100) doses of medication may be purchased regardless of the prescribed dosage schedule for: (1-16-80)

i. Cardiac glycosides; and (1-16-80)

ii. Thyroid replacement hormones; and (1-16-80)

iii. Prenatal vitamins; and (1-16-80)

iv. Nitroglycerin products; and (1-16-80)

v. Fluoride and vitamin/fluoride combination products; and (2-4-91)

vi. Nonlegend oral iron salts. (2-4-91)

b. Oral contraceptive products will be purchased in a quantity sufficient for one (1), two (2), or three (3) cycles. (1-16-80)

05. Comparative Cost to be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs. (11-10-81)

06. Dispensing Procedures.

a. To obtain a prescription drug, a MA recipient must present his identification card to a participating pharmacy together with a prescription from a licensed physician, dentist, osteopath, nurse practitioner, or podiatrist. (11-10-81)

b. Refills of prescription drugs must be authorized by the prescriber and recorded on the prescription or on the recipient's medication profile by pharmacists. (11-10-81)

c. The Idaho Medical Assistance Drug Program requires that MA prescriptions be dispensed according to the rules and regulations, Chapter 17, Title 54, Idaho Code; Chapter 27, Title 37, Idaho Code; the Idaho Uniform Controlled Substances Act; and Idaho State Board of Pharmacy Rules and Regulations. (11-10-81)

d. Prescriptions not filled in accordance with the provisions of Section 126. will be subject to nonpayment or recoupment. (12-31-91)

e. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for utilization review purposes by the Department with a minimum of twenty-four (24) hours prior notification. (11-10-81)

07. Payment Procedures. (11-10-81)

a. Pharmacists must file claims by submitting the appropriate claim form to the Department. Upon request, the Department will provide pharmacies with a supply of claim forms and instructions. The form submitted must include the following information: (11-10-81)

i. Patient's name and identification number; and (11-10-81)

ii. The medication, prescriber, quantity of drug dispensed, and the usual and customary charge for each particular prescription. (11-10-81)

b. Each claim form is subject to review by a Medical Claim Examiner, a Pharmaceutical Consultant, and a Medical Consultant. (11-10-81)

c. Pharmacists' billed charges are not to exceed the usual and customary charges to the general public for the same product and quantity. (1-16-80)

d. Reimbursement to pharmacies must be limited to the lowest of the following costs: (1-16-80)

i. Maximum Allowable Cost (MAC), as established by the Pharmaceutical Reimbursement Board, U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; or (11-10-81)

ii. Estimated Acquisition Cost (EAC), as established by the Department plus the assigned dispensing fee; or (1-16-80)

iii. The pharmacy's usual and customary charge to the general public. (1-16-80)

e. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient in a long term nursing care facility except: (11-10-81)

i. For the multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence indi-

cates that the quantity issued at each dispensing incident does not relate to the recipient's known monthly requirements for that specific medication; and (11-10-81)

ii. For oral liquid maintenance drugs if a reasonable quantity, as determined by the Department, is dispensed at each filling; and (11-10-81)

iii. If a thirty-four (34) day supply of the drug is excessive, in the judgment of the Department. (11-10-81)

f. Claims are processed by computer and payments are made directly to the pharmacy. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (11-10-81)

127. DENTURIST SERVICES. (3-1-92)

01. Payment. Payment will be available for the following specific procedures when provided by licensed denturists who are participating providers in the Medicaid Program: (3-1-92)

a. Complete denture, upper; (3-1-92)

b. Complete denture, lower; (3-1-92)

c. Immediate denture, upper; (3-1-92)

d. Immediate denture, lower; (3-1-92)

e. Adjust complete denture, upper; (3-1-92)

f. Adjust complete denture, lower; (3-1-92)

g. Adjust partial denture, upper; (3-1-92)

h. Adjust partial denture, lower; (3-1-92)

i. Repair broken complete denture base; (3-1-92)

j. Replace missing or broken teeth, complete denture (each tooth); (3-1-92)

k. Repair resin saddle or base; (3-1-92)

l. Repair cast framework; (3-1-92)

m. Repair or replace broken clasp; (3-1-92)

n. Repair broken teeth per tooth; (3-1-92)

o. Add tooth to existing partial denture; (3-1-92)

p. Add clasp to existing partial denture; (3-1-92)

q. Reline complete upper denture (chairside); (3-1-92)

r. Reline complete lower denture (chairside); (3-1-92)

s. Reline upper partial denture (chairside); (3-1-92)

t. Reline lower partial denture (chairside); (3-1-92)

u. Reline complete upper denture (laboratory); (3-1-92)

v. Reline complete lower denture (laboratory); (3-1-92)

w. Reline upper partial denture (laboratory); (3-1-92)

x. Reline lower partial denture (laboratory); (3-1-92)

02. Denturist Services -- Limitations. Denture construction is covered no more frequently than every five (5) years. (3-1-92)

03. Payment Procedure.

a. The Department will pay the lower of either the billed charge or the Department's maximum reimbursement rate (see Section 060.). (3-1-92)

b. All claims must be submitted on the American Dental Association (ADA) claim form. (3-1-92)

128. -- 129. (RESERVED).

130. INDIAN HEALTH SERVICE CLINICS. (7-1-93)

01. Care and Services Provided. Payment will be available to Indian health service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Sections 050. through 155. (12-31-91)

02. Payment Procedures. (7-1-93)

a. Payment for services other than prescribed drugs ~~and dental services~~ will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. ~~(11-10-81)~~ (7-1-97)

b. Payment for prescribed drugs will be available as described in Section 126. (12-31-91)

c. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (11-10-81)

d. ~~Payment for dental services will be made on a fee for service basis as described in Subsections 100.03. through 100.05.~~ ~~(12-31-91)~~

The provisions of Section 030., "Third Party Liability," are not applicable to Indian health service clinics. (12-31-91)

131. -- 134. (RESERVED).

135. CHIROPRACTIC SERVICES. The Department will pay for a total of two (2) office visits during any calendar month for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition demonstrated to exist by x-ray. (9-1-82)

136. -- 139. (RESERVED).

140. PHYSICAL THERAPY SERVICES. The Department will pay for physical therapy rendered by a licensed physical therapist if such services are ordered by the attending physician as part of a plan of care. (7-1-85)

01. Payment Procedures. (7-1-93)

a. Each recipient is limited to one hundred (100) visits of outpatient physical therapy during any calendar year. Visits to out patient departments of hospitals and from home health agencies or independent physical therapists providing physical therapy are included in the limit on the total outpatient physical therapy visits. (3-22-93)



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b. Licensed, independently practicing physical therapists and home health agencies must send a copy of the patient's attending physician's order for physical therapy services to the Department with their claims. (7-1-85)

i. Physical therapy rendered by home health agencies or by independently practicing physical therapists must have, at least every sixty (60) days, physician recertification, in writing, that those services were necessary. This information must be on the copy of the physician's order submitted with the claim. (7-1-85)

ii. Physical therapists identified by Medicare as independent practitioners will be paid on a fee-for-service basis. The maximum fee paid will be based upon the Department's fee schedule. Only these practitioners can bill the Department directly for their services. (7-1-85)

iii. Physical therapy provided by home health agencies will be paid at a rate per visit as described in Section 105. (12-31-91)

c. Physical therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (3-22-93)

d. Physical therapy services rendered by nursing home facilities to outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (7-1-85)

e. Payment for physical therapy rendered to inpatients in long-term care facilities is made directly to the facilities as part of their operating costs. (7-1-85)

f. Payment for physical therapy ordered in an Adult and Child Development Center or its equivalent, according to Section 120., will be made directly to that center. Payment will be based upon the Department's fee schedule for those services. (12-31-91)

141. -- 143. (RESERVED).

143. WAIVER SERVICES FOR ADULT DEVELOPMENTALLY DISABLED RECIPIENTS. Pursuant to 42 CFR section 440.180, it is the intention of the Department to provide waiver services to eligible recipients in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to achieve and maintain community integration. For a recipient to be eligible, the Department must find that the recipient requires services due to a developmental disability which impairs their mental or physical function or independence, be capable of being maintained safely and effectively in a non-institutional setting and would, in the absence of such services, need to reside in an ICF/MR. (1-1-95)T

01. Services Provided. (1-1-95)T

a. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to an eligible recipients which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (1-1-95)T

i. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one or more of the following areas: self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; money management including training

or assistance in handling personal finances, making purchases, and meeting personal financial obligations; daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the recipient to their community. Training associated with participation in community activities includes assisting the recipient to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the recipient to continue to participate in such activities on an on-going basis. Such services do not include participation in nontherapeutic activities which are merely diversional or recreational in nature; mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (1-1-95)T

ii. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the recipient or the recipient's primary caregiver(s) are unable to accomplish on his own behalf. (1-1-95)T

iii. Skills training to teach waiver recipients, family members, alternative family caregiver(s), or a recipient's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (1-1-95)T

b. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the recipient's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the recipient, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the recipient. (1-1-95)T

c. Respite care services which are those services provided, on a short term basis, in the home of either the waiver recipient or respite provider, to relieve the person's family or other primary caregiver(s) from daily stress and care demands. While receiving respite care services, the waiver recipient cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to recipients who reside with *non*-paid caregivers. (1-1-95)T

d. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive

employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (1-1-95)T

i. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available/funded under the Rehabilitation Act of 1973 as amended, or IDEA; and the waiver participant has been deinstitutionalized from an NF or ICF/MR at some prior period. (1-1-95)T

ii. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver recipients to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (1-1-95)T

e. Transportation services which are services offered in order to enable waiver recipients to gain access to waiver and other community services and resources required by the individual support plan. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State plan, defined at 42 CFR 440.170(a), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. In no case will the spouse be reimbursed for the provision of transportation services under the waiver. (1-1-95)T

f. Environmental modifications which are those interior or exterior physical adaptations to the home, required by the waiver recipient's support plan, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver recipient would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver recipient, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, or central air conditioning. All services shall be provided in accordance with applicable State or local building codes. Environmental modifications are limited to modifications to a home rented or owned by the recipient or the recipient's family when the home is the recipient's principal residence. (1-1-95)T

g. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the Individual Support Plan which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation. (1-1-95)T

h. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver recipient safety and/or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the

provision of communication connection systems. PERS are limited to recipients who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (1-1-95)T

i. Home delivered meals which are designed to promote adequate wavier recipient nutrition through the provision and home delivery of one to two meals per day. Home delivered meals are limited to recipients who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (1-1-95)T

j. Therapy services under the waiver include physical therapy services; occupational therapy services; and speech, hearing and language services. These services are be available through the waiver when the need for such services exceeds the therapy limitations under the State plan. Under the waiver, therapy services will include: (1-1-95)T

i. Services provided in the waiver recipient's residence, day habilitation site, or supported employment site; (1-1-95)T

ii. Consultation with other service providers and family members; (1-1-95)T

iii. Participation on the recipients Individual Support Plan team. (1-1-95)T

k. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the Individual Support Plan which are within the scope of the Nurse Practice Act and are provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. (1-1-95)T

l. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of recipients who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs a recipient. These services also provide emergency back-up involving the direct support of the recipient in crisis. (1-1-95)T

02. Place of Service Delivery. Waiver services for developmentally disabled recipients may be provided in the recipient's personal residence, specialized family home, waiver facilities, day habilitation/supported employment program or community. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (1-1-95)T

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (1-1-95)T

b. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (1-1-95)T

c. Licensed Residential Care Facility; and (1-1-95)T

d. Adult foster homes. (1-1-95)T

e. Additional limitations to specific services are listed under that service definition. (1-1-95)T

03. Services Delivered Following a Written Plan. All waiver services must be authorized by the ACCESS Unit in the Region where the recipient will be residing and provided based on a written Individual Support Plan (ISP). (1-1-95)T

a. The ISP is developed by the ISP team which includes: (1-1-95)T

h. Personal Emergency Response Systems must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (1-1-95)T

i. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (1-1-95)T

i. Provide assurances that each meal meets one third of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; and (1-1-95)T

ii. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (1-1-95)T

iii. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three days per week; and (1-1-95)T

iv. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; and (1-1-95)T

v. Provide documentation of current driver's license for each driver; and (1-1-95)T

vi. Must be inspected and licensed as a food establishment by the District Health Department. (1-1-95)T

j. All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan. (1-1-95)T

k. Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing. (1-1-95)T

l. Behavior Consultation/Crisis Management Providers must meet the following: (1-1-95)T

i. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist; and (1-1-95)T

ii. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or (1-1-95)T

iii. Be a licensed pharmacist; or (1-1-95)T

iv. Be a Qualified Mental Retardation professional. (1-1-95)T

v. Emergency back-up providers must meet the minimum provider qualifications under Residential Habilitation services. (1-1-95)T

07. Recipient Eligibility Determination. Waiver eligibility will be determined by the Regional ACCESS Unit. The recipient must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, Section 634, "Eligibility for the Aged, Blind, and Disabled (AABD)." The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver recipients must meet the following requirements: (1-1-95)T